Ascension

The Honorable Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

June 17, 2022

Submitted electronically via: www.regulations.gov

RE: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; etc. (CMS-1771-P)

Dear Administrator Brooks-LaSure:

Ascension appreciates the opportunity to submit comments in response to the proposed rule entitled *Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation (CMS-1771-P)* (the "FY 2023 IPPS proposed rule"), as issued by the Centers for Medicare & Medicaid Services (CMS).[1]

Ascension is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. As one of the leading non-profit and Catholic health systems in the U.S., Ascension is committed to delivering compassionate, personalized care to all, with special attention to persons living in poverty and those most vulnerable. In FY2021, Ascension provided $2.3 billion in care of persons living in poverty and other community benefit programs. Ascension includes more than 150,000 associates and 40,000 aligned providers. The national health system operates more than 2,600 sites of care – including 143 hospitals and more than 40 senior living facilities – in 19 states and the District of Columbia.

In addition to overarching concerns and recommendations to ensure the hospital system is both adequately positioned for the next surge and able to maintain robust services within our communities, we offer the following comments in response to many of the provisions and requests for information (RFIs) outlined by CMS in the proposed rule, largely in the same order as outlined in the preamble–and not necessarily reflective of relative importance. We greatly appreciate CMS's consideration of these comments and look forward to our continued engagement on these and other important issues:

- **Overarching Comments; IPPS Rate Updates and Impact of the Proposed Rule**. We discuss challenges facing health systems today as a result of the ongoing COVID-19 pandemic, and encourage CMS to refrain from adopting policies that will deepen current financial difficulties exacerbated by the pandemic.

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[1] 87 Fed. Reg. 28,108 (May 10, 2022).

- **Request for Information on Social Determinants of Health Diagnosis (SDOH) Codes.** We provide information on Ascension's experience with the use of Z-codes and recommendations to promote and optimize use.
- **Recalibrating the MS–DRG Relative Weights.** We propose a targeted approach for weighting COVID-19 MS-DRGs that promotes accurate payment for such patients, minimizing impacts on other MS-DRGs.
- **Rural, Imputed, and Frontier Floors and Low Wage Index Hospital Policy.** We encourage CMS to align with the current court's ruling to diminish potential instability and complications for hospitals if CMS is ultimately barred from implementing this policy.
- **Permanent Cap on Wage Index Decreases.** We support CMS's proposal to cap annual reductions in hospital wage indexes but encourage CMS to address the need for more comprehensive wage index reform and ask CMS to refrain from implementing this policy in a budget neutral manner.
- **Disproportionate Share (DSH) and Uncompensated Care Payments (UCP)**. As uncompensated care costs continue to rise while Medicare UCP continues to decline, we encourage CMS to account for additional data when calculating Factors 1 and 2.
- **1115 Waiver Days in the Medicare Fraction**. We strongly recommend CMS refrain from adopting the policy as proposed, given the potential impacts on patient access to care, and caution CMS that the proposal related to premium assistance will be exceedingly difficult to implement absent clearer guidance.
- **Low Volume Hospitals and Medicare Dependent Small Rural Hospitals**. We encourage CMS to work with Congress to make these critical programs permanent.
- **Indirect and Direct Graduate Medical Education Costs**. We support CMS's proposal to modify the weighting of certain full-time equivalent residents.
- **Hospital-Acquired Conditions (HAC) Reduction Program (RP)**. We support the proposed data suppression for FY 2023 and FY 2024 and continued use of data for Care Compare.
- **RFI: Climate Change Impacts on Outcomes, Care, and Health Equity**. We highlight Ascension's extensive efforts to mitigate against climate emergencies and climate change, as well as their impacts on our communities, and offer recommendations on how CMS can increase support for hospitals' efforts.
- **RFI: Measuring Healthcare Quality Disparities Across CMS Quality Programs**. We highlight Ascension's efforts to address disparities and encourage CMS to focus on driving toward standardization of data capture and measurement, leveraging resources currently available and accessible to providers, and streamlining administrative burden across programs.
- **RFI: Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs**. Ascension supports CMS's outlined approach to advancing toward digital data and retrieval of data from primarily FHIR-based endpoints and we encourage CMS to maintain a methodological approach to implementation.
- **RFI: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)**. Ascension strongly supports the broad goal of TEFCA to scale electronic health information exchange nationwide and ensure secure access for all patients to their electronic health information.
- **Hospital Inpatient Quality Reporting (IQR) Program**. We offer input on proposed measures related to maternal health, opioid-related adverse events, and the potential future addition of two CDC measures.
- **Medicare Promoting Interoperability Program (PIP)**. We offer input on proposals related to the Health Information Exchange (HIE) Objective, the Public Health and Clinical Data Exchange Objective, and the Patient Access to Health Information Measure RFI.

- **Condition of Participation: Reporting COVID-19 and Influenza Infections**. Ascension supports the alignment of infectious disease reporting but identifies challenges that should be addressed to ensure successful implementation.
- **RFI: Payment Adjustments for Domestically Made N95 Respirator Masks.** We encourage CMS to provide payment adjustments as proposed and to examine incentives to purchase additional domestically produced PPE, such as gloves, gowns and other supplies.

Overarching Comments; IPPS Rate Updates and Impact of the Proposed Rule

Over the course of the last two and a half years, Ascension has been focused on two overarching priorities: caring for patients and caring for our associates. We are immensely grateful for the selfless dedication of our caregivers throughout the pandemic. They have been the healing hands and hearts of our healthcare system and in their communities–showing up to care for patients during this extraordinary time. As of the end of March 2022, Ascension hospitals nationally had cared for more than 136,000 COVID inpatients and approximately 776,000 COVID outpatients. Yet for many clinicians and health systems, including Ascension, the first quarter of calendar year 2022 was the most operationally and financially challenging stretch of the entire pandemic. Driven by a multitude of factors, the Omicron surge in January and February had a significant impact on our frontline caregivers, contributing to the ongoing exhaustion and unprecedented burnout rates. In fact, Omicron has had an even greater impact than what was experienced in March 2020. We had record numbers of associates who were on paid furlough due to COVID infection or exposure; even with very high vaccination rates among caregivers, Omicron left a record number of caregivers and staff exposed or infected, with more than 39,000 having to take paid leave to quarantine or recover -- 48 percent of the paid furloughs for the entire pandemic were caused by the Omicron surge.

The combined influx of patients and the depletion of our caregivers required Ascension and many other health systems to rely on contract labor to provide patients the care they deserve, driving up demand and costs. These necessary contracts led to an unprecedented 300% year over year spike in contract labor costs. At one point in recent months, Ascension incurred contract labor costs in one month that were equivalent to what we would normally spend in an entire year. And while there wasn't a federally mandated shutdown of non-emergency procedures, it was still necessary for many systems to delay scheduled procedures, either to make beds available for COVID patients or because of staffing limitations. During peak surge times, across the entire system we had more than 500 beds closed across our system because of lack of staffing – the equivalent of one of our large hospitals.

We have also incurred substantial added costs to ensure we are prepared for future surges and supply chain challenges. We changed our supply distribution and established additional distribution centers to ensure we had the equipment and supplies that our staff needed to get through any additional surges of COVID. Today, as compared to pre-pandemic, we spend roughly 8.5% more to stock our hospitals with the lifesaving medications and supplies our patients need, including an 8% increase in drug costs, a 5% increase in personal protective equipment (PPE)/General Medical and Surgical supplies, and a stark 15.1% increase in lab costs.

Given the expected persistent nature of these combined factors – increased labor and supply costs and shifts in patient utilization – we anticipate ongoing losses in the coming months, even as we continue implementing best efforts to mitigate against such significant losses. We are thus exceedingly concerned that CMS is proposing policies for FY 2023 that will result in net reductions in payments to hospitals after the more than two years of pandemic driven crisis response efforts outlined above, anticipated ongoing pressures, and impending future surges.

For FY 2023, CMS proposes a market basket update of 3.1%, less a productivity adjustment of 0.4 percentage points, plus a documentation and coding adjustment of 0.5 percentage points, resulting in an update of 3.2%. This update, as well as the FY 2022 payment update of 2.7%, are woefully inadequate and do not capture the unprecedented inflationary environment. This is because the market basket is a time-lagged estimate that uses historical data to forecast into the future. When historical data is no longer a good predictor of future changes, the market basket becomes inadequate. We therefore strongly encourage CMS to provide an increase to the market basket greater than the proposed 3.1%. At a minimum, we recommend CMS implement a market basket adjustment for a net increase of at least 5%, in line with the 5.1% increase in hospital expenses demonstrated via comparison of hospital costs from Federal FY (FFY) 2020 against FY 2019 Healthcare Cost Report Information System (HCRIS). Examples of cost increases that CMS should include in the market basket update largely include, but are not limited to, increased labor costs. We also urge CMS to implement a retrospective adjustment in FY 2023 to account for the difference between the market basket update that was implemented for FY 2022 and what the market basket is currently projected to be for FY 2022. As noted above, in response to COVID-19 pressures, hospitals have paid and can often continue to pay 200% more than in prior years for travel nurses, with additional losses ranging from $5 million to $9 million *per hospital* due to workforce turnover. These added costs are not immediately captured in Medicare, Medicaid, or most commercial rates but create significant and unsustainable financial pressures that we cannot continue to shoulder independently and require urgent adjustment.

For these same reasons, we urge CMS use its authority to eliminate the -0.4% Affordable Care Act (ACA) Productivity Adjustment cut for any year impacted by the COVID-19 Public Health Emergency (PHE), and proceed cautiously with additional policy proposals on which CMS has statutory discretion and that have the potential to create either financial hardship or significant administrative burden.

In addition, we are concerned about the dramatic scale of the proposed increase in the high-cost outlier threshold—a 39% increase from the FY 2022 threshold—that would significantly decrease the number of cases that qualify for an outlier payment. We appreciate that CMS has taken steps to account for some of the pandemic-related factors that may have driven the increase, but which will likely not continue fully in FY 2023. However, we urge the agency to explain in more detail the factors driving this significant increase in the IPPS high-cost outlier threshold—the largest by far in the past decade. Specifically, we ask CMS to examine its methodology more closely and consider making additional, temporary changes to help mitigate the substantial increases that are still occurring in the outlier threshold.

Collectively, each of the components comprising Medicare reimbursement updates under the IPPS, as well as many of the complex policy proposals addressed below, have the potential to either ensure hospitals are adequately positioned for the next surge and able to maintain robust services within our communities–or they have the potential to exacerbate the current financial hardships, administrative burdens, and resources constraints that hospitals are currently navigating. We strongly urge CMS to take this confluence of factors into consideration and offer hospitals some much-needed relief, particularly around labor-related updates and reimbursement mechanisms designed to support programs and facilities that are providing a significant amount of community benefit and care to the poorest and most vulnerable in our communities.

Request for Information on Social Determinants of Health Diagnosis (SDOH) Codes

CMS solicits public comment on how the reporting of diagnosis codes in categories Z55- Z65 (Persons with potential health hazards related to socioeconomic and psychosocial circumstances) may improve the agency's ability to recognize severity of illness, complexity of illness, and utilization of resources under the Medicare Severity Diagnosis Related Groups (MS-DRGs). CMS believes that reporting SDOH Z-codes in inpatient claims data could enhance coordination within hospitals across their clinical care and discharge planning teams, including post-acute partners.

Ascension has been engaged in tracking and analyzing the use of Z-codes across our ministry. Our data science team's analysis has found that over the past three years, the two most commonly used Z-codes are homelessness (Z59.0) and unemployment (Z56.0), followed by personal history of sexual abuse in childhood (Z62.810), problems related to primary support group including separation and divorce (Z63), and problems related to education and literacy (Z55). Of note, our team found that roughly 30% of all Z-codes documented are related to housing. Additionally, based upon our analysis of existing data, we found that patients with documented Z-codes for homelessness are often very complex and correlated encounters are frequently for psychosis, substance use disorders, and other behavioral health conditions. Patients who had homelessness Z-codes documented in their medical records, in our review, had 60% higher rates of readmission within 90 days than patients who indicated they had access to stable housing; in fact, we found that roughly one in every three such patients returned to the hospital within 90 days. Specifically, we are working in Detroit, MI, where we are partnering with other community organizations to build permanent supportive housing units for previously homeless individuals within one mile of our Detroit emergency department in order to address this issue.

Simiarly, we believe our finding that sexual abuse in childhood was one of the most frequently documented Z-codes, in combination with a known relationship between adverse childhood events and health outcomes, suggests more should be done to capture these codes in the healthcare setting. For example, research shows "that the adversity we experience as a child can affect how our stress response functions, leading to long-term changes in our brains and bodies and leading to health problems as an adult. Experiencing 4 or more [adverse childhood events] is associated with significantly increased risk for 7 out of 10 leading adult causes of death, including heart disease, stroke, cancer, COPD, diabetes, Alzheimers and suicide."[2] Collectively, these findings suggest that the reporting of these Z-codes may improve the ability to better recognize severity or complexity of illness.

We appreciate CMS's acknowledgement that there are still several reasons why providers and facilities are not reporting Z codes at higher rates, including the fact these codes are not currently required and that patients are often not comfortable with or willing to discuss the underlying issues. We believe these known barriers support the need for a comprehensive approach to address SDOH. Ideally, this would include interconnected partnerships between all levels of government, the private sector, payors, philanthropic organizations, and community- and faith-based organizations. Additionally, infrastructure for data exchange should be established, as such data is essential in helping health systems better anticipate needs and help vulnerable patients receive support at both the individual and population levels. To that end, we also found that hospitals caring for a greater numbers of patients documented as experiencing homelessness were at a disadvantage when participating in programs that incentivize readmission avoidance but do not account for underlying social determinants; without identifying and addressing these root cause risk factors, the ability to improve health outcomes is inherently limited. The ideal collection approach would thus draw in data from all available sources, not just health providers, and create an interoperable flow of SDOH data in the community for screening, referrals, and resolving unmet needs. Additionally, as CMS considers mandatory reporting, this kind of data standardization and infrastructure would help prevent undue provider burden. Education and support mechanisms, including use of incentives, would significantly improve the acquisition of SDOH data.

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[2] See, [How ACEs Affect Health | Center for Youth Wellness](#).

Recalibrating the MS–DRG Relative Weights

Using the FY 2021 claim data, CMS has observed that COVID-19 cases are increasing the relative weights for the MS-DRGs where these cases are grouped. For instance, MS-DRG 870 (Septicemia or Severe Sepsis with MV >96 hours) has a 9 percent higher relative weight including COVID-19 cases relative to excluding them. As CMS believes there will be fewer COVID-19 cases in FY 2023 than FY 2021, CMS is proposing to determine the relative weight for the MS-DRGs where COVID cases are grouped by averaging the relative weights calculated with and without COVID-19 cases. By averaging the relative weights, CMS believes the result will reflect a more accurate estimate of the relative resource use for the cases treated in FY 2023 than if no special adjustment were made. CMS also proposes a permanent 10 percent annual cap on the reduction in a MS-DRG's relative weight beginning with FY 2023.

Ascension encourages CMS to carefully evaluate in coordination with stakeholders any policy that might unintentionally limit the reimbursement rates for COVID-19 cases. We appreciate the implications of excessive rate growth for certain groupings within the IPPS, but the persistence of COVID-10 within our communities and the cost pressures outlined above strongly suggest the need to ensure reimbursement remains sufficient and appropriate. To that end, we support increasing the relative weights for the MS-DRGs where documented COVID-19 infection cases are grouped, given the costs and complexity associated with caring for such patients. To constrain excess reimbursement rates, however, we recommend CMS consider a process that differentiates patients who test asymptomatically for COVID-19 infection from those beneficiaries for whom a COVID-19 infection is causing clinical symptoms to worsen. This approach would better target the more resource intensive beneficiaries without artificially constraining reimbursement for their care.

Rural, Imputed, and Frontier Floors and Low Wage Index Hospital Policy

CMS is proposing to continue the agency's policy to increase wage indexes below the 25th percentile by one-half the difference between the hospital's otherwise applicable wage index and the 25th percentile wage index value for FY 2023. For FY 2023, the 25th percentile wage index value across all hospitals is 0.8401. CMS is proposing to apply a budget neutrality adjustment of -0.18 percent for this policy. CMS notes that this policy has been the subject of pending litigation, in which the court recently found that the Secretary did not have statutory authority to adopt the low wage index hospital policy and ordered additional briefing on the appropriate remedy. CMS is continuing to evaluate the court's decision which is subject to appeal. Although CMS proposes to continue this policy for FY 2023, it may take a different approach in the final rule, depending on public comments or developments in the court proceedings.

Given CMS's acknowledgement below that predictability in Medicare payments is important to enable hospitals to budget and plan their operations, Ascension recommends that CMS finalize a policy in line with the court's decision as the case continues on appeal, to diminish potential instability and complications for hospitals if CMS is ultimately barred from implementing this policy. As noted below, we encourage CMS to continue working with stakeholders and Congress to address the need for more comprehensive reforms that better address underlying issues with wage index policy that continue to impact the accuracy of Medicare reimbursement for many hospitals. If CMS proceeds with this policy, we strongly encourage CMS to refrain from implementing this policy in a budget neutral manner.

Permanent Cap on Wage Index Decreases

In response to a comment solicitation in the FY 2022 IPPS/Long Term Care Hospital (LTCH) PPS proposed rule, commenters recommended CMS consider making a maximum 5 percent annual reduction to the wage index permanent. While CMS did not adopt such a suggestion for FY 2022, the agency recognizes significant year-to-year fluctuations in an area's wage index can occur due to external factors beyond a hospital's control that are difficult to predict. CMS indicates that predictability in Medicare payments is important to enable hospitals to budget and plan their operations. For these reasons, CMS is proposing a 5 percent cap on annual reductions to hospital wage indexes effective for FY 2023.

We appreciate CMS's proposal to cap annual reductions in hospital wage indexes but encourage CMS to continue working with stakeholders and Congress to address the need for more comprehensive reforms that better address underlying issues with wage index policy that continue to impact the accuracy of Medicare reimbursement for many hospitals. We also strongly encourage CMS to refrain from implementing this policy in a budget neutral manner.

Disproportionate Share (DSH) and Uncompensated Care Payments (UCP)

With respect to proposed FY 2023 Factor 1, CMS estimates this figure based on the most recent data available. It is not later adjusted based on actual data. CMS used the Office of the Actuary's (OACT) January 2022 Medicare DSH estimates, which were based on the September 2021 update of the HCRIS and the FY 2022 IPPS final rule impact file. OACT's January 2022 Medicare estimate of DSH payments for FY 2023 is $13.266 billion. The proposed Factor 1 amount is seventy-five percent of this amount, or $9.949 billion. The proposed Factor 1 for 2023 is about $540 million less than the final Factor 1 for FY 2022. With respect to proposed FY 2023 Factor 2, for FY 2023, CMS estimates that the uninsured rate for the historical, baseline year of 2013 was 14 percent and for CYs 2022 and 2023 is 8.9 percent and 9.3 percent, respectively. As required, the Chief Actuary of CMS certified these estimates. CMS calculated Factor 2 for the FY 2023 proposed rule to be 0.6571 or 65.71 percent, and the uncompensated care amount for FY 2023 to be $6.538 billion, which is about $654 million less than the FY 2022 UCP total of about $7.192 billion; the percentage decrease is 9.1 percent.

Ascension is concerned that uncompensated care costs continue to rise while Medicare UCP continues to decline. We note that this proposed rule marks the first year of the UC pool in which Factor 1 costs have decreased. Constraining uncompensated care payments to safety net hospitals in the context of ongoing financial pressures facing hospitals compounds the uncertainty related to future surges and patient acuity arising out of deferred care, and broader fiscal patterns that have the potential to increase the number of uninsured and underinsured patients. Reducing UCP in this context only puts in jeopardy access to services for these patients and those Medicare beneficiaries who traditionally obtain care in otherwise under-resourced areas. To ensure appropriate reimbursement that supports the ongoing delivery of care to critically vulnerable patients and improved outcomes, we strongly encourage CMS to provide additional UC DSH funding in FY 2023 by, among other things:

- *Increasing the Factor 1 Discharge Adjustment.* The proposed FY 2023 Factor 1 discharge adjustment is 7 percentage points less in FFY 2023 as compared to FY 2022. In other words, CMS is reducing UC DSH payments based on a projection of fewer discharges in FY 2023 than in FY

2022. CMS notes the data used for FY 2023 is based on preliminary data, which likely includes claims from 2021 and approximately three months of 2022. We encourage CMS to consider the limitation of any data in the latter parts of CY 2021 and early CY 2022 used in the projection of discharges in FY 2023 and to increase the Factor 1 discharge adjustment. We further request that CMS normalize any data used in its Factor 1 projections from CY 2021 and CY 2022, which are impacted by the COVID-19 Delta and Omicron variants. Furthermore, Ascension believes this request for an increase to the Factor 1 discharge adjustment is further supported by and consistent with CMS's expectation–noted in the April 2022 Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies–that Medicare "utilization will begin to rebound."[3]

- *Increasing the Factor 1 Case Mix Adjustment.* The Factor 1 update for the case mix adjustment is a reduction of 0.9900 for FY 2022 and FFY 2023 (the FY 2021 case mix adjustment factor is 1.0290). We recommend an increase to the Factor 1 CMI adjustment and encourage CMS to consider recent trends on increased length of stay and higher acuity of care resulting from delayed procedures when calculating the projected CMI update for FY 2023.

- *Increasing Factor 2 Adjustment to Account for Anticipated Disenrollments.* As CMS is well aware, the CARES Act prohibits states from determining Medicaid eligibility for Medicaid beneficiaries through the PHE. With the potential for the PHE to end in 2023, it is estimated that between 14 and 15 million individuals will lose Medicaid coverage, thus increasing the uninsured population. Similarly, the American Rescue Plan (ARP) provided enhanced Exchange subsidies but projections suggest the uninsured population will grow by another three million individuals as these ARP subsidies expire on December 31, 2022. In light of these impending increases in uninsured patients, we urge CMS to ensure these projections are fully captured in the Factor 2 calculation.

1115 Waiver Days in the Medicare Fraction

CMS reviews its history of when patient days of expansion groups could be included in Medicaid inpatient days for calculating the Medicare DSH patient percentage. The proposed rule states that CMS's intent has been to include patient days of those populations who, under a demonstration project, receive benefits, including inpatient hospital coverage benefits, that are similar to the benefits provided to traditional Medicaid beneficiaries. This would not include circumstances where states extended coverage only for specific services (such as family planning) and that do not include insurance coverage for hospital care. CMS also states that it does not believe that the uninsured patients whose costs are partially offset by uncompensated care pools can be "regarded" as being eligible for Medicaid and thus patient days paid from such pools and other similar sources should not be included in the calculation of the Medicare DSH adjustment. Likewise, CMS believes the days of patients who under a section 1115 expansion waiver receive premium assistance (assistance used to purchase health insurance from a private entity) should also be excluded from the calculation of the DSH calculation. CMS explains that because these individuals do not directly receive health insurance for inpatient hospital services and may have higher incomes than traditional Medicaid beneficiaries, it does not believe these days should be included in the numerator of the Medicaid fraction. CMS notes that, recently, courts have decided in a series of cases that, based on the current language of the regulations, CMS is required to count in the numerator of the Medicaid fraction patient days for which hospitals have received payment from an uncompensated care pool authorized by a section 1115 demonstration and the days of patients who receive premium assistance under a section 1115 demonstration program.

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[3] *See,* Announcement of Calendar Year (CY) 2023 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies, April 4, 2022 (at 58), available at: https://www.cms.gov/files/document/2023-announcement.pdf

CMS proposes to modify its regulations to explicitly state its view that "regarded as eligible" for Medicaid only includes patients who receive health insurance through a section 1115 demonstration where state expenditures to provide the insurance may be matched with funds from Title XIX (Medicaid). Furthermore, CMS proposes to use its discretion under the Act to include only the days of patients "regarded as" eligible for Medicaid who receive health insurance through a section 1115 demonstration that provides essential health benefits (EHB) as set forth in 42 CFR part 440, subpart C, for an Alternative Benefit Plan, which is a uniform benchmark and a standard that is broadly used. Consistent with its interpretation of the Medicare DSH statute, CMS proposes to amend its regulation to preclude counting days of patients associated with uncompensated/undercompensated care pools in the numerator of the Medicaid fraction. CMS views these as essentially supplemental Medicaid DSH payments. It believes that because funding pool payments to hospitals do not inure any specific individual, nor do uncompensated/undercompensated care pools provide any health insurance to any patient, it cannot reasonably be argued that patients associated with uncompensated care for which hospitals are reimbursed through section 1115 demonstration-authorized funding pools may be regarded as eligible for Medicaid.

CMS concludes, however, that patients receiving premium assistance through a section 1115 demonstration to purchase health insurance can be "regarded as" eligible for Medicaid under section 1886(d)(5)(F)(vi). CMS proposes, for purposes of the DSH calculation, to "regard as" eligible for Medicaid those patients who use premium assistance they obtain through a section 1115 demonstration to buy and pay for all or substantially all of the cost of the health insurance. CMS further proposes to include in the Medicaid fraction only those days of patients who have bought health insurance that provides EHB using premium assistance obtained through a section 1115 demonstration that is equal to at least 90 percent of the cost of the health insurance. Individuals who receive less premium assistance are not receiving benefits similar to the benefits received by individuals eligible for Medicaid under a State plan and would be excluded from the Medicaid fraction. CMS proposes that these changes would be effective for discharges occurring on or after October 1, 2022.

As noted in prior comments, the most concerning downstream consequences of CMS's proposal to exclude days of patients associated with uncompensated/undercompensated care pools in the numerator of the Medicaid fraction are those likely to impact patient access to vital healthcare services at and through safety net hospitals. In particular, uncompensated care pools provide assurances that otherwise uninsured patients can obtain life-sustaining care. While payment for such services might not funnel through an insurance or insurance-like program, patients are nonetheless able to receive care for which payment is ultimately made (at least in part) with Medicaid funds. And while such payments generally do not make hospitals whole for the cost of care rendered to applicable patients, they still provide a funding stream that supports the provision of services to these and other individuals. In other words, these waiver programs effectively stand in the shoes of more traditional coverage options for both individuals and hospitals in states that might otherwise not be positioned to offer such coverage options.

Ascension has long supported and advocated for achieving 100% coverage and 100% access for all persons living in this country. We believe all individuals should have access to meaningful coverage that in turn facilitates access to necessary healthcare services. As progress towards this goal continues to be made, a number of state Medicaid programs continue to rely on uncompensated care pools established under 1115 waivers to facilitate access to care for covered residents. Given the ongoing role that uncompensated care pools play for many individuals who might otherwise be Medicaid eligible, but for their place of residence, we strongly encourage CMS to refrain from adopting the proposed changes to its regulations. Furthermore, we align ourselves with the comments offered by other hospitals and health systems that outline the extent to which this proposal violates both judicial instruction across multiple cases and the statutory bounds of CMS's authority. **Thus, unless and until such demonstration programs are no longer a major source of access and funding for many, excluding individuals otherwise covered under such programs will ultimately add additional strain to the safety net that provides care for the poorest and most vulnerable.** We urge CMS not to adopt this proposal to exclude patient days in the Medicaid fraction numerator for patients whose care was covered in part by section 1115 uncompensated care pools.

Furthermore, we caution CMS that the proposal to include only those days of patients who have bought health insurance that provides EHB using premium assistance obtained through a section 1115 demonstration that is equal to at least 90 percent of the cost of the health insurance will be exceedingly difficult if not outright impossible for hospitals to administer. We respectfully urge CMS, if the agency elects to finalize this policy, to provide hospitals with a comprehensive list of the programs CMS would consider eligible for inclusion. Absent this information from CMS, it is almost entirely impossible for hospital staff to know with any degree of certainty whether such patients' coverage meets the thresholds outlined above. We strongly caution CMS that hospitals do not have access to this kind of information at the patient level, which will potentially differ not only by state but by individual based on their personal contributions, and the number of patients to whom this policy will apply is likely so small that the administrative investment will offer diminishing returns. Hospitals and systems would individually need to obtain agreement from the applicable state programs in order to obtain the requisite level of data on percentage of cost contributed; there is no guarantee states can or will provide such data completely, accurately, and at the individual level.

To that end, numerous states have implemented innovative programs to facilitate patient access to coverage. It is difficult to understate the significant complexity that would be associated with determining whether a given patient receiving premium assistance meets the proposed multi-pronged test to be "regarded as" eligible for Medicaid. This kind of assessment would be excessively burdensome for hospital staff–if not entirely impossible–and exceedingly likely to create complications and added burden during audits as well. As a multi-state health system, Ascension is well aware of the many other variations on "premium assistance" programs and not only do **we strongly reiterate that CMS should expressly identify for hospitals which programs should be included or excluded (rather than requiring hospitals to devote previous limited resources to attempting to make such difficult determinations). We also caution CMS that without greater clarification around covered programs, this proposal would not only be exceedingly difficult–if not impossible–for hospitals to accurately administer, but could leave ambiguity sufficient to create discrepancies in how Medicare Administrative Contractors (MACs) define and include (or exclude) certain premium assistance programs and enrollments.**

Low Volume Hospitals and Medicare Dependent Small Rural Hospitals

Section 1886(d)(12) of the Act provides a payment in addition to a hospital's IPPS payment for each qualifying low-volume hospital beginning in FY 2005. To qualify as a low-volume hospital, the hospital must be more than a distance specified in the statute from another IPPS hospital and have fewer than a statutory specified number of discharges. Absent statutory intervention, only hospitals with less than 200 total discharges will be eligible for the low volume hospital adjustment beginning in FY 2023. Section

1886(d)(5)(G) of the Act provides special payments under the IPPS to a Medicare-dependent, small rural hospital (MDH) through September 30, 2022. Absent congressional action, beginning with discharges occurring on or after October 1, 2022, all hospitals that previously qualified for MDH status will no longer be eligible for this special payment methodology. CMS notes that while the MDH program was set to expire many times previously, it has always been extended by Congress. Nevertheless, at this time, CMS is advising hospitals of the MDH program expiration and the potential to ameliorate the associated reduction in payment through becoming a sole community hospital (SCH).

While Ascension recognizes that the extension of these programs is within the purview of Congress, we reiterate for CMS the critically important nature of these programs for rural hospitals and their communities–in which we are not only primary sources of healthcare services, but employment as well. In light of the ongoing COVID pandemic and financial pressures outlined herein, we strongly encourage CMS to work with Congress to ensure these are extended or made permanent, including the current eligibility and payment parameters.

Indirect and Direct Graduate Medical Education Costs

In response to recently concluded litigation, CMS is proposing to implement a modified policy applicable to all teaching hospitals, effective October 1, 2001. CMS's new policy would cover cost reporting periods for which many Notices of Program Reimbursement (NPRs) have already been settled. Specifically, CMS proposes the following: if the hospital's weighted full-time equivalent (FTE) resident count is equal to or less than the FTE cap, no adjustment is necessary; and if the hospital's weighted FTE count is greater than the FTE cap, CMS will adjust the weighted FTE to make the total weighted FTE count equal the FTE cap as detailed further in the proposed rule.

We appreciate CMS's responsiveness to the court's decision and support the proposal outlined by CMS.

Hospital-Acquired Conditions (HAC) Reduction Program (RP)

CMS proposes to suppress all six HAC RP measures for program year FY 2023 and not to calculate measure scores or Total HAC Scores. Absent Total HAC Scores, no hospitals would be penalized under the HAC RP for the year, and associated changes to results reporting are proposed. CMS also clarifies how removal of the No Mapped Location policy will be implemented for program year FY 2023. Further, CMS announces technical specifications updates to the CMS Patient Safety and Adverse Results Composite (CMS PSI 90) measure volume threshold, effective beginning with program year FY 2023. For program year FY 2024, CMS proposes to suppress FY 2021 data from all five Hospital Associated Infections (HAI) measure calculations.

We appreciate CMS's recognition that the unprecedented nature of the COVID-19 pandemic and ongoing surges have created new and complex circumstances within health care settings that need to be managed, and that COVID-19 infected patients have had higher risk factors for infection. Across the entire health care system, many of the tracked CMS reportable HAIs were negatively impacted by higher infection rates, with varying patterns observed in response to COVID surges and geographically-diverse waves. In addition, CMS's PHE-related HAI reporting waivers for CY2020 resulted in disparate reporting across the country. For these reasons, we support the HAI data suppression from the HAC Reduction Program for FY 2023 and FY 2024. We also support continued use of the data for Care Compare public reporting purposes.

RFI: Climate Change Impacts on Outcomes, Care, and Health Equity

CMS requests information about hospital responses to climate change from several perspectives: (1) how patient populations are being affected, especially underserved groups; (2) how hospitals and the healthcare sector can effectively prepare for climate threats; (3) how CMS can support hospitals in crafting and implementing hospital responses; and (4) approaches hospitals are using to reduce their own greenhouse gas emissions.

Ascension's commitment to reduce its environmental impact and achieve sustainability is rooted in its Mission, which calls us to be advocates for a compassionate and just society in actions and words. Through Catholic social teaching, Ascension recognizes the human dignity of all people and the common good as it works toward equitable access to resources to improve community health and the lives of individuals and communities served.

The heart of Ascension's Environmental Impact and Sustainability program is healthy communities: exploring the relationship between sustainability and the social determinants of health; and linking this to Ascension's Mission to sustain and improve community health and the lives of individuals we are privileged to serve. And, given our footprint across much of the South and Southeast, Ascension has seen significant increases in climate related weather events like hurricanes, tornado watches and warnings, and extreme heat days. We also know that lower-income communities often face considerable pollution and other climate change impacts that affect their physical health. Additionally, extreme weather conditions brought about by climate change affect SDOH, which are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.

Ascension has thus taken steps to ensure our facilities are resilient and able to continue serving the community in times of climate emergency, but many of the requisite measures (like backup generators that are generally powered by diesel fuel) impact the carbon footprint of the healthcare system. And whether these climate-related events impact our facilities or not, they frequently require a response from local teams. In the case of hurricanes, tornadoes, storm watches and warnings, this response can range from clearing outdoor debris, securing construction, and moving patients to hallways and more secure areas. This has an effect on patients, families, and others who have scheduled emergency and normal procedures, and adds a cost to the facility with interrupted procedures and additional staff costs. These may not rise to the level of a federal disaster declaration, which means there is no opportunity to receive public assistance grants from FEMA.

Beyond crisis response resiliency, the Ascension Environmental Impact and Sustainability Program started in 2008 with a focus on energy efficiency. In 2011, Ascension joined 60 founding members in the Department of Energy's Better Buildings Challenge to reduce energy consumption. Ascension was one of two health systems originally involved in the challenge, and set a bold goal to reduce energy use by 20 percent by 2020. Ascension's efforts were rewarded in December 2016 when it reached its Better Buildings Challenge goal of 20 percent energy reduction more than three years ahead of schedule. The Program's long-term goals are focused on achieving Net Zero carbon emissions and Zero Waste across all sites of care by 2040. Interim science-aligned targets will support these broader goals to ensure continuous progress and improvement in the Program. For example, the current targets are focused on reduction of greenhouse gas emissions by five percent and waste sent to landfill by six percent by FY23 as an interim step towards the organization's long-term goals.

The Program includes implementing business practices and healthcare delivery strategies that achieve its environmental goals; increase climate resiliency in our communities; exceed federal, state, and local environmental laws and regulations; and promote corporate citizenship and the common good. In addition, a Committee of the Ascension Board conducts a quarterly review of progress toward Ascension's Environmental Impact and Sustainability goals and targets. Implementing sustainable practices mitigates climate change. A focus on aggressively reducing carbon dioxide (CO2) emissions supports the goal of the Paris Climate Agreement of 2015, limiting global temperature increases to 1.5 degrees Celsius compared to pre-industrial levels. Ascension's commitment to achieve net zero carbon by 2040 is a recognition that we must be a leader in this work to help the world achieve the goal by 2050 and avoid a global temperature increase beyond 1.5 degrees Celsius.

Ascension seeks to create and support a resource efficient, cost-effective and resilient ecosystem of facilities and real estate with a sustainable physical presence. In addition, we are leveraging our purchasing power to influence a cost-effective, healthy, circular and resilient value chain that catalyzes change toward a value-based care model, in alignment with Ascension's commitment to holistic care for the person and the common good as well as to Catholic social teaching. In addition, we will examine communities and social determinants of health and design programs and processes that support interventions to address environmental effects on patients and create healthier environments in the communities that Ascension serves. Ascension's bold goals will infuse sustainability into important business decisions across the organization.

Ascension hospitals also participate in regional transportation planning; provide vouchers for public transportation; promote ride sharing; provide bike racks and showering facilities to promote active transportation and provide electric vehicle charging stations. For example, Ascension Texas hospitals participated in Austin's Mobility 20/20 program with a 2039 goal for half of Austin residents to travel to work without driving alone in a car. The program's strategies allow residents to safely and efficiently commute by transit, foot, bike, scooter, or carpool. The COVID-19 pandemic illustrated how many businesses can adapt to a telework environment and maintain productivity.

Additionally, TRIMEDX, Ascension's biomedical engineering partner, has deployed 23 hybrid vehicles at Ascension sites used by biomedical engineers to service medical equipment. The fleet vehicles are used to carry tools and parts, so small SUVs are ideal for this purpose. Hybrids are purchased as TRIMEDX replaces vehicles in order to achieve fuel and maintenance savings over the life of the vehicles, as well as reducing pollution by moving away from fossil fuels. Through our mobility work group, Ascension is developing strategies to convert the Medxcel and Ascension fleets to electric vehicles and recently purchased its first electric vehicle as a pilot project.

In 2021, Ascension developed a new sustainability strategy and rolled out the new Environmental Impact and Sustainability Program focused on the following three pillars:

1. *Net Zero Places.* This pillar is focused on carbon sources associated with physical environments — energy management, water management and mobility, both moving within those environments and getting to and from them. Net Zero Places considers the carbon footprint and operational efficiency of facilities as well as sustainable transportation. Ascension seeks to create and support a resource-efficient, cost-effective and resilient ecosystem of facilities and real estate with a sustainable physical presence.

2. *Responsible Supply Chain.* This pillar is focused on the flow of goods from their procurement all the way through their disposition after use—encompassing sustainable sourcing, product usage management, recycling and waste management. Responsible Supply Chain efforts address responsible purchasing—to ensure Ascension buys only what is needed—as well as waste management. Together, these efforts will lower environmental impact and provide social good. Ascension's Responsible Supply Chain seeks to create and support a cost-effective, healthy, circular, and resilient value chain that catalyzes change toward a value-based care model, in alignment with Ascension's commitment to holistic care for the person and the common good as well as to Catholic social teaching. Ascension has a tremendous opportunity to optimize its work in supply chain management on what comes in and out of its facilities as well as the impact on the footprint that it leaves behind.

3. *Healthy Communities.* Most of Ascension's work up to this point has focused on realizing energy savings and thinking differently about how to construct and operate facilities. The heart of the Environmental Impact and Sustainability Program is focused on efforts toward achieving Healthy Communities. This pillar is focused on the relationship between sustainability and social determinants of health, linking this back to Ascension's Mission to sustain and improve the health of individuals and communities the ministry is privileged to serve. This includes examining communities and social determinants of health and designing programs and processes that support interventions to address environmental effects on patients and create healthier environments in the communities that Ascension serves. This pillar aligns with efforts to integrate Mission and Catholic identity within Ascension's Strategic Plan.

All of this work is led by a Sustainability Team, which includes eleven full-time sustainability experts focused on this transformative work. They are supported by the Environmental Impact Office which is a group of subject matter experts from across the organization focused in nine work groups on the following areas:

- Energy - conservation and procurement of renewable sources;
- Mobility - fleet electrification and charging infrastructure;
- Built Environment - standards to infuse sustainability in new facilities;
- Sourcing - managing scope 3 emissions with supply chain vendors;
- Waste Management - increasing recycling efforts across 20+ streams;
- Healthy Communities - embracing sustainability as a social determinant of health;
- Reporting - collecting data to report on progress towards net zero carbon;
- Communications - engaging all Ascension associates in our sustainability journey; and
- Governance and Change Management - management of the program.

Finally, Green Teams lead and customize the implementation of sustainability initiatives for each market to maximize local impact. They have a standing report at the Environment of Care Committee at each hospital and report through that committee to the local administrator responsible for operations.

In October of 2021, Ascension announced its commitment to and participation in the United Nations' Race to Zero campaign and has pledged: Net Zero carbon emissions by 2040 with a 50 percent reduction in carbon emissions by 2030; recycling 50 percent of non-hazardous waste from all managed facilities by 2030; and Zero Waste by 2040. Ascension also has goals in place for reduction of Greenhouse Gas emissions and waste to landfill through FY23. The Sustainability Team is currently working on new goals for FY24 to carry the organization to a 50 percent reduction in carbon emissions and recycling of 50 percent of nonhazardous waste from all managed facilities by 2030. Once those goals are achieved, the organization will finalize the path to Net Zero Carbon and Zero Waste by 2040.

In terms of challenges and opportunities for CMS to support hospitals in crafting and implementing hospital response, we note that many sustainability initiatives, like converting hospitals from natural gas heat to renewable energy sources, will be challenging from an operational reliability and financial standpoint. Federal and state funding will be important to drive adoption and offset the expense of initiatives that are the right thing, yet do not yield a positive return on investment. Additionally, organizational bandwidth to address sustainability has been diverted during the global pandemic. Ascension has been focused on patient care, supply chain, facility readiness, staffing challenges and financial difficulties during the COVID-19 pandemic and many of those challenges and the associated financial impacts are expected to persist into the foreseeable future. Finally, even as one of the largest health systems in the United States, Ascension has limited influence with suppliers to impact Scope 3 emissions. Our opportunity to reduce items purchased for care delivery is a challenge. The healthcare manufacturing sector is outside our direct control but must reduce carbon emissions to move the dial on Ascension's Scope 3 emissions.

The primary obstacle to accessing assistance programs aimed at reducing our carbon footprint has been the reliance on tax incentives as the primary incentive. As a not-for-profit entity, those incentives cannot be utilized by Ascension and the majority of healthcare providers. Ascension has attempted to utilize federal, state and local incentives for on-site renewable energy installations in the past, but it requires a complex partnership with for-profit entities who can utilize the tax incentives. The legal complexity and need to share benefits with a for-profit partner have curtailed use of the incentives. It would be helpful to consider other federal incentives that are not tax-based to support decarbonization. For example, direct incentives would make it much easier for Ascension to mitigate the sustainability impact of its 80+ million square feet of facilities. We also suggest that costs incurred from "no-notice" disasters–like those noted above–be considered for public assistance, even if little or no damage is incurred, given the impact on patients, families, and communities. In addition, it is difficult to assess the benefit of assistance programs across 19 states and hundreds of local communities. A central repository of information would dramatically simplify the process of identifying the programs that align with our footprint and organizational goals. And as organizations contemplate transitioning to renewable sources of electricity in place of burning fossil fuels on site, federal investments to support a national power transportation grid will be important to connect the most optimal source of renewable energy to all regions of the continental United States.

RFI: Measuring Healthcare Quality Disparities Across CMS Quality Programs

CMS notes that health inequity, manifested by significant disparities in healthcare outcomes, persists in the United States, particularly for individuals belonging to underserved communities. CMS describes health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes."

In this RFI, CMS describes key principles and approaches the agency will consider when addressing disparities through quality measure development and stratification. Topics for comment and supporting information provided are grouped by CMS around 5 key considerations: Identification of Goals and Approaches for Measuring Healthcare Disparities and Using Measure Stratification Across; Guiding

Principles for Selecting and Prioritizing Measures for Disparity Reporting; Principles for Social Risk Factor and Demographic Data Selection and Use; Identification of Meaningful Performance Differences; and Guiding Principles for Reporting Disparity Measures.

From the beginning of our ministry, Ascension has been wholly committed to serving all persons, with special attention to those who are poor and vulnerable, and to improving the health and well-being of our communities. In advancing health equity for the persons we serve, Ascension's vision is that every person receiving care has the opportunity to attain his or her full health potential, while no one is disadvantaged from achieving this potential because of race, ethnicity, culture, religion, socioeconomic status, healthcare access, or other socially-determined circumstances. We understand that achieving health equity requires eliminating unjust barriers to the normal range of health opportunities, which can be environmental, social, financial, as well as barriers endemic to the healthcare system itself. Achieving health equity thus requires valuing everyone equally, with focused and ongoing efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. We also understand that achieving an equitable healthy community requires a systematic and collaborative approach.

Our long-standing and relentless commitment to enabling our patients to achieve health equity focuses on several areas, including:

- Identifying and eliminating disparities in health outcomes (due to race, ethnicity, religion, language preference, place of residence, insurance status, or income) and removing gaps in care;
- Strengthening our workforce by equipping all of our associates, including an engaged core of nurses, physicians and advanced care clinicians, with tools to competently and compassionately serve our diverse populations;
- Strengthening our Community Health Ministry to serve our persons where they live, work and, play, and collaborating with like-minded partners to provide care needs;
- Advocating for quality and affordable access to healthcare and therapeutics for all persons we serve; and
- Fostering a culture of diversity and inclusion across all areas of our ministry that enriches our leadership, governance, associates, and diversity of suppliers – reflecting the communities we serve. This includes launching, within the past two years, a new justice-focused framework called ABIDE, which is built upon the hallmarks of Appreciation – Belongingness – Inclusivity – Diversity – Equity.[4] Our commitment is to Listen–Pray–Learn–Act on matters of disparities and inequities.

In recent years, Ascension has undertaken a systemwide effort to make healthcare more equitable. Ascension's leadership has called on all our sites of care to establish national goals around healthcare equity and to reduce disparities. We believe that improving health equity involves addressing the societal risk factors that have an impact on vulnerable populations' health. To achieve these goals, Ascension convened health equity forums, attended by hundreds of our system and facility leaders. The conclaves were used to further leaders' understanding of variables driving health inequity and to develop strategies. Out of our work, a five-pronged strategy was developed that includes:

- Establishing health equity as a strategic priority for all of Ascension's care sites, including hospitals, long-term care facilities, and outpatient locations;
- Putting in place structures and processes to ensure that Ascension facilities can collect and use patient demographic and socioeconomic data **in a standardized way**—including the collection of patient race, ethnicity, language, and gender identity data system wide;

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[4] Additional information can be found at: https://www.ascension.org/Our-Mission/diversity-and-inclusion

- Deploying specific strategies including clinical improvement initiatives that address social risk factors related to health;
- Decreasing the implicit bias that staff may have when delivering care, such as misunderstandings that may arise when patient and caregiver do not speak the same language, or have different ethnicities or belief systems; and
- Partnering with community organizations and historically black colleges and universities to develop pipeline programs to improve health and health equity.

As CMS recognizes, in vulnerable communities, even if quality care is available, social and economic factors often prevent individuals from being able to obtain healthcare services or achieve health goals. These can include: food security; housing; employment and income/poverty level; domestic and community violence; crime/public safety; environment (*e.g.*, clean water and air); healthy workplaces, schools, and transportation; literacy, educational attainment, and early childhood development; and social cohesion or civic engagement. While there are many ways providers work to help address the underlying social conditions affecting their patients' health, the American Hospital Association has identified three general paths – which may provide a guide for considering how best to support providers working to address risk factors among patients:

- *Screening and information*: Providers systematically screen patients, either remotely or in person, for health-related social needs and discuss with patients the impact this may have on their health.
- *Navigation*: Providers offer navigation services to assist patients in accessing community services.
- *Alignment*: Providers partner with community stakeholders to align more closely local services with the needs of patients.

Data Capture, Measurement, and Stratification

In response to CMS's RFI, we again strongly encourage CMS to focus its efforts on driving toward standardization of data capture and measurement, leveraging resources currently available and accessible to providers, and streamlining administrative burden across programs. As noted above, it is critical for Ascension that our providers are able to uniformly assess and identify potential social risk factors among all patients – including Medicare beneficiaries – using one "language" or approach, because patients are not defined merely by their coverage status or carrier. We have also found that standardization is vital to our success in driving towards health equity, as it will foster the development and sharing of best practices within and among clinical settings, health systems, and delivery designs. Today, however, we must navigate and seek commonalities across differing assessment standards that have been implemented across the myriad programs and sites of care that exist today.

The Agency for Healthcare Research and Quality (AHRQ) has found that "[o]ne of the biggest barriers most health systems face in improving quality and reducing disparities within their own walls is systematically identifying the populations they serve, addressing the needs of these populations, and monitoring improvements over time."[5] AHRQ further found that the principal challenges in obtaining race, ethnicity, and language data for use in quality improvement assessments include **a lack of standardization and understanding of why the data are being collected**.[6] And as key thought leaders have recently articulated, "while essential, vigilance and evaluation alone are insufficient for achieving greater equity. The idea that disparities are 'unintended' consequences of payment policy must be abandoned, and instead, an **explicit new intention and goal must be set to reduce disparities through payment programs**."[7]

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[5] AHRQ, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, Introduction* (April 2018), at: https://www.ahrq.gov/research/findings/final-reports/iomracereport/reldata1.html

[6] *Id*.

As such, we encourage CMS to consider robust education for beneficiaries on the need to share information that is often sensitive and highly personal, as well as for providers on the availability and utility of existing billing codes. CMS could offer such education while developing additional codes for social needs care that could be made available across Medicare, Medicaid, and private insurance providers, as need is identified. This approach would help to incentivize increased and improved screening and data collection, which can in turn facilitate referrals for social service supports. One option CMS should evaluate is better leveraging and promoting uptake of the existing set ICD-10 "Z" codes, as discussed above. CMS should also consider utilizing data from self-reporting via portal questionnaires.

As CMS looks to collect, evaluate, stratify, and provide feedback on measured data, we also encourage CMS to consider leveraging actionable and readily available data that might seem otherwise routine; in fact, one opportunity for strategically changing inequities upstream can start by finding the geographic distribution of health, particularly the life expectancy by zip code. This information demonstrates the power of geography in determining health outcomes as well as conveying the unfair nature of the distribution of health. Measuring and stratifying by zip code will identify geographic disparities but also provide an avenue for location-based approaches to reducing inequities in health outcomes. Other recent recommendations suggest that "existing performance measures could also be used not only to measure how clinicians perform overall, but how they perform for marginalized patients. Early candidates for this use could include measures that capture conditions and areas of care where both clinicians can influence outcomes and marginalized patients face well-known disparities (*e.g.*, hypertension and cancer screening). Using this approach. . . could also guide efforts to link equity-based measures to risk adjustment, incentives, and other components of payment programs."[8]

Ascension has been purposeful about impacting disparities through organizational efforts, programs, and communications. **While we wholeheartedly embrace implementation of these types of equity-focused efforts, and encourage their adoption, we caution CMS against the implementation of mandatory or specifically defined measures.** Allowing hospitals and health systems the flexibility to attest to adoption of various organizational practices aimed at promoting health equity, and to leverage programs that work best for their system and structure, will allow for more meaningful and robust adoption of a variety of efforts and approaches, rather than implementation for the mere sake of attestation.

RFI: Fast Healthcare Interoperability Resources (FHIR) in Hospital Quality Programs

CMS seeks broad input on the transition to digital quality measurement. First, CMS provides an updated definition for digital quality measures (dQMs): quality measures, organized as self-contained measure specifications and code packages, that use one or more sources of health information that is captured and can be transmitted electronically via interoperable systems. CMS seeks feedback on the updated dQM definition and on challenges associated with non-EHR sources of patient data for dQMs. CMS also seeks input on data standardization to leverage and advance standards for digital data, approaches to achieve FHIR electronic clinical quality measure (eCQM) reporting, and venue for continued feedback. Ascension supports CMS's outlined approach to advancing toward digital data and retrieval of data from primarily FHIR-based endpoints. We believe it will be important to continue a measured and step-wise approach to moving these efforts forward, and strongly encourage CMS to maintain this methodological approach by allowing vendors to update their systems ahead of the need for implementation. We also believe the outlined establishment of standardization across implementation guides and value sets is a critical next step to enable this reporting and especially important to reduce barriers with non-EHR sources.

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[7] Liao JM, Lavizzo-Mourey RJ, Navathe AS. *A National Goal to Advance Health Equity Through Value-Based Payment*. JAMA. Published online June 04, 2021. doi:10.1001/jama.2021.8562.

[8] Liao, et al., at E2.

RFI: Advancing the Trusted Exchange Framework and Common Agreement (TEFCA)

CMS notes that Version 1 of TEFCA was released by the Office of the National Coordinator (ONC) for Health Information Technology (HIT) on January 18, 2022. Goals for TEFCA include establishing a universal policy and technical floor for interoperability, simplifying connectivity for organizations to securely exchange HIT to improve patient care, and enabling individuals to gather their own healthcare information.

Ascension strongly supports the broad goal of TEFCA to scale electronic health information (EHI) exchange nationwide and ensure secure access for all patients to their electronic health information. A number of existing challenges must still be addressed to ensure success of TEFCA, including healthcare adoption of robust data governance and management, difficulty in identification and matching patients records, lack of compatible technology for exchange across vendor platforms, maturity of FHIR-based APIs to exchange all EHI, and significant related costs. As CMS continues a measured approach to advancing system data exchange capabilities, we encourage CMS to thoughtfully sequence all components so that vendors and providers have adequate development and implementation time, vendors are incentivized to ensure that data exchange is able to be utilized efficiently in their software by providers, and there is adequate time provided for outreach and education initiatives for both providers and patients. Many providers are concerned that the proposed implementation timeline fails to recognize both the operational complexity in implementing the required technology, does not address needed provider and patient education or the lack of mature standards or technology for the proposed data elements and effective seamless exchange. In addition, we note that community providers will need education and implementation support to enable their engagement and ability to implement exchange.

Hospital Inpatient Quality Reporting (IQR) Program

CMS proposes changes to the IQR program that would add 10 new measures including several related to health equity and two focused on maternal health and perinatal care.

Maternal Health: New Measures & Hospital Designation

CMS proposes adding an eCQM, *Cesarean Birth*, to the Hospital IQR Program measure set, beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years. The measure is intended to facilitate safer maternal care by assessing the rate of low-risk, Nulliparous Term Singleton Vertex (NTSV) pregnancies delivered by Cesarean section (C-section) as a step towards reducing the rate of non-medically indicated C-sections and their associated excess morbidity, mortality, and costs. CMS also proposes adding an eCQM, *Severe Obstetric Complications*, to the Hospital IQR Program measure set, beginning with voluntary reporting for the CY 2023 reporting period and mandatory reporting beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years. The measure assesses the proportion of patients with severe obstetric complications that occur during inpatient delivery hospitalizations and is intended to facilitate safer care by increasing awareness of major obstetric complications and their associated morbidity and mortality and through encouraging adherence to clinical guidelines.

Furthermore, CMS proposes to establish a hospital designation reflecting the quality and safety of maternal care for use that would be publicly reported on a public-facing CMS website beginning in Fall 2023. The designation would be awarded to hospitals that report “Yes'' to both questions embedded in the Maternal Morbidity Structural Measure of the Hospital IQR Program, including: (1) Does your hospital or health system participate in a Statewide and/or National Perinatal Quality Improvement Collaborative Program aimed at improving maternal outcomes during inpatient labor, delivery and postpartum care; and (2) Has your hospital implemented patient safety practices or bundles related to maternal morbidity to address complications, including, but not limited to, hemorrhage, severe hypertension/preeclampsia or sepsis? CMS indicates its intention to expand the requirements for hospitals to be awarded the maternal care quality and safety designation, solicits names for the proposed designation, and requests input on additional sources of data other than the Maternal Morbidity Structural Measure.

Ascension strongly supports CMS’s efforts to improve maternal health outcomes across the country. Ascension has undertaken a system-wide effort to improve maternal health outcomes for all patients and to reduce disparities related to access and outcomes in vulnerable populations. These efforts include, among other things: reducing CDC-defined severe maternal morbidities with incremental reductions in populations experiencing health disparities; improving access to prenatal and postpartum care with incremental improvements in populations experiencing health disparities; amd a strategic focus to improve maternal health access for vulnerable populations, including implementing a social initiative to identify and address barriers to care. We have invested a large effort into Ascension’s HANDS™ program, which promotes safer deliveries and addresses competencies for clinicians supporting the delivery process through program components that include early elective delivery bundle, shoulder dystocia bundle and modules, fetal heart rate monitoring, obstetrical hemorrhage, and hypertension.

As one targeted effort to ensure we are focusing our efforts on this critically important aspect of patient care, we have been actively monitoring our system wide outcomes and performance with respect to the Joint Commission Perinatal Care Measure PC-02: Cesarean Section. A number of our hospitals also have dedicated initiatives in place that are specifically focused on appropriately reducing primary C-sections. Given our shared goals and focus on this aspect of maternal care, we support CMS’s proposal to add the eCQM, *Cesarean Birth*, to the Hospital IQR Program measure set. As CMS evaluates outcomes on this measure, we strongly encourage the agency to consider that social risk factors contributing to a 10-year projection of increasing birth risk that are substantially outside of a facility’s control (e.g., obesity rates) may be driving utilization rates–and we encourage CMS to account for those factors in scoring this measure.

Similarly, we support CMS’s proposal to add an eCQM, *Severe Obstetric Complications*, to the Hospital IQR Program measure set. This proposal aligns closely with work that is under way as part of Ascension’s Severe Maternal Morbidity project. This project, among other efforts, aims to address the stark reality that maternal morbidity rates have risen by around 190% nationally over the past 20 years, with significant disparities for minorities, uninsured and underinsured women, and in lower socioeconomic areas. We agree with CMS that adding this measure will maintain a heightened level of awareness across hospitals related to severe maternal morbidities and race-based disparities in maternal outcomes.

We also support CMS's proposal to establish a hospital designation reflecting the quality and safety of maternal care as a way to reduce maternal morbidity and maternal mortality. We have established a national collaborative of 37 sites across Ascension, through the Ascension Perinatal Quality Committee and Quality collaborative, and we rely on Premier–and industry leader–as one of our benchmark databases, among others. Several Ascension hospitals also participate in statewide collaboratives to share and learn best practices for improving quality of care for mothers and babies. System-wide, we have implemented bundles related to shoulder dystocia, reducing early elective deliveries, and managing hypertension, sepsis, and obstetrical hemorrhage–all of which have been stood up to improve our maternal care delivery and outcomes. All of this work also highlights a factor we encourage CMS to consider; there are currently multiple agencies and private organizations focused on improving outcomes in this area, which are ultimately resulting in duplication of efforts to study and report on maternal quality. We therefore strongly encourage CMS to take into account a hospital or health system's participation in one of the myriad other measure reporting programs and collaboratives that exist today when assessing a hospital's qualification for any applicable designation and be explicit in any implementing regulations which of these programs and collaboratives CMS will recognize. Overall, however, we applaud CMS for the agency's ongoing efforts to improve maternal health, particularly as it relates to addressing healthcare disparities and improving health equity.

Hospital Harm—Opioid-Related Adverse Events

CMS proposes adding an eCQM *Hospital Harm—Opioid-Related Adverse Events* to the Hospital IQR Program measure set beginning with the CY 2024 reporting period/FY 2026 payment determination and for subsequent years. The measure uses naloxone (opioid-antagonist) administration as a marker for adverse events, most of which are avoidable, triggered by opioid administration to inpatients. The measure is intended to provide information to hospitals to improve their monitoring of and response to inpatients given opioids.

At Ascension, we are currently monitoring naloxone utilization in the inpatient setting, where a patient has received an opioid within six hours prior to the naloxone administration. We agree with CMS that this measure would provide hospitals with reliable and timely measurement of their opioid-related adverse event rates, which is a high-priority measurement area. We also agree that implementation of this measure can lead to safer patient care by incentivizing hospitals to implement or refine clinical workflows that facilitate evidence-based use and monitoring when administering opioids. For these reasons, a similar metric related to inpatient naloxone administration has become an important part of our *Recognize and Rescue Toolkit*, which is designed to reduce patient harm from opioid administration.

Given our experience to date, we note that there are some ancillary uses of naloxone, including for indications such as itching or constipation, which are unrelated to opioid oversedation; we have therefore undertaken efforts aimed at removing those instances from our evaluation and encourage CMS to similarly exclude such non-oversedation uses of opioid antagonists from the measure, as well, and work with stakeholders on evaluating the most administratively feasible approach(es) to doing so. For hospitals and health systems like Ascension that have already begun measuring inpatient naloxone use, the development of multi-state internal dashboards takes a great deal of time and resources. Reporting on new and specified eCQM would require additional resource investment to match the specific parameters of such a new measure. However, we agree there is a great value in understanding the results of such a measure on a national, system-wide level, and ascertaining a “benchmark” for facilities to work towards (ideally achieving a naloxone use for oversedation of opioids of zero).

Furthermore, while we appreciate CMS’s focus on naloxone, we note there is a newly released opioid antagonist product called Nalmefene, which has been on the market about 6 months. We encourage CMS to consider including this additional opioid antagonist medication in the definition of the eCQM.

Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) HAI measures; RFI on Long Term Care Hospital (LTCH) Measure

CMS seeks input on the potential future addition of two CDC NHSN HAI measures: (1) Clostridioides difficile CDC NHSN Health-Associated Infection (HA-CDI) Outcome Measure (“CDI C.diff”); and (2) CDC NHSN Hospital-Onset Bacteremia and Fungemia Outcome Measure. Similarly, in a subsequent section of the proposed rule, CMS solicits input into requiring electronic submission of quality data from LTCHs via their EHRs as part of the LTCH quality reporting program (QRP). Specifically, CMS poses questions related to the future inclusion of the NHSN Healthcare-Associated Clostridioides difficile Infection Outcome Measure (HA-CDI) as the LTCH QRP’s first digital quality measure (dQM).

Ascension applauds CMS for considering the use of less burdensome surveillance-driven HAI data, but we caution that, in our experience to date, these metrics are not fully mature. We would recommend CMS wait until these metrics are fully vetted and evaluated further, including validation testing, feasibility, ease of extraction electronically, and time and cost impact studies. For example, we understand the NHSN Antimicrobial Use and Resistance (AUR) metric was supposed to be easily extractable from the EHR (e.g., the antibiotic given), but we were unable to extract the data easily across all of our EHRs or clinical decision support (CDS) software. We encourage CMS to ensure these new measures do not unintentionally undermine CMS’s goal of decreasing provider burden by delaying implementation until full maturity is achieved.

We note that the CDI C.diff outcome measure includes a positive laboratory test plus treatment for C.difficile, but have observed that some hospitals opt to skip the test and proceed with treatment only. Ascension believes this approach runs counter to optimal patient care and antimicrobial stewardship practices, yet these hospitals will likely score well according to CMS. This likewise can be punitive to hospitals that test appropriately and treat appropriately. Additionally, the NHSN Bacteremia and Fungemia metric includes ‘all organisms’ in blood cultures. We are concerned that this definition can be extremely wide ranging (e.g. include skin flora, gut pathogens, etc.) and the data may not be specific enough to provide any meaningful and actionable information. Furthermore, we again note that financial and staffing constraints arising out of the pandemic mean necessary IT and technology resources remain limited, making it difficult to divert attention to electronically sourced data requirements, particularly in low income and under-resourced healthcare settings (*e.g.*, rural hospitals).

In response to the RFI on LTCH QRP inclusion, Ascension is generally supportive of the use of objective and easily collected data via an electronic methodology, preferably from the EHR. However, we reiterate the concerns noted above and caution that LTCHs may be even further constrained in terms of available EHR capabilities, IT support, and technology necessary to build the report or interface. We also note that medication administration may be separately documented outside of the EHR. We strongly recommend that a transition period of at least one calendar year be provided, based on availability and accessibility of software and IT support. Finally, we note that the challenges to HAI reporting in LTCHs largely derive from limited resources around infection prevention staffing, training, and turn over.

Medicare Promoting Interoperability Program (PIP)

CMS reminds stakeholders that participants are only required to use technology meeting the certified electronic health record (EHR) technology (CEHRT) definitions during a self-selected EHR reporting period or performance period of a minimum of any consecutive 90 days in CY 2023 which would include the final 90 days of 2023.

Health Information Exchange (HIE) Objective

In the FY 2022 IPPS/LTCH PPS final rule, the HIE Bi-Directional Exchange measure was finalized under the HIE Objective. The measure is worth 40 points (the total amount of points available under the HIE Objective) and is an alternative to reporting on the two existing HIE Objective measures. Eligible hospitals and CAHs must attest to 3 statements. CMS proposes to reduce the total amount of points available for the HIE Objective to 30. For 2023, CMS proposes three reporting options under the HIE objective: (1) report on both the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure; (2) report on the HIE Bi-Directional Exchange measure; or (3) report on the proposed Enabling Exchange Under TEFCA measure.

The Enabling Exchange Under TEFCA measure would be reported by attestation, and the measure would require a “yes/no'' response. CMS proposes that the measure may be calculated by reviewing only the actions for patients whose records are maintained using CEHRT. Eligible hospitals and CAHs would attest to the following:

- Participating as a signatory to a Framework Agreement (in good standing that is not suspended) and enabling secure, bi-directional exchange of information to occur, in production, for all unique patients discharged from the eligible hospital or CAH inpatient or emergency department (POS 21 or 23), and all unique patient records stored or maintained in the EHR for these departments, during the EHR reporting period in accordance with applicable law and policy.
- Using the functions of CEHRT to support bi-directional exchange of patient information, in production, under the Framework Agreement. Eligible hospitals or CAHs would have to use the capabilities of CEHRT to support bidirectional exchange under a Framework Agreement, which includes capabilities that support exchanging the clinical data within the Common Clinical Data Set (CCDS) or the United States Core Data for Interoperability (USCDI).

Ascension strongly believes that achieving nationwide healthcare data interoperability is necessary for optimizing patient care and we strongly support the addition of the Enabling Exchange Under TEFCA measure. However, we encourage CMS to refrain from reducing the HIE objective points attainable and to continue working instead to implement additional incentives for provider adoption and expansion of data exchange. In lieu of penalties, we believe the current needs related to infrastructure investment and vendor capabilities suggest that incentives are far more likely to promote and enable the success of TEFCA and nationwide interoperability efforts. We also encourage CMS to consider the need for additional education across both providers and beneficiaries around that need for interoperability, the use and privacy protection of healthcare data, and the benefits of interoperability to patient care.

Public Health and Clinical Data Exchange Objective

Beginning with the EHR reporting period in 2023, CMS proposes to require reporting on a fifth measure under the Public Health and Clinical Data Exchange Objective: AUR Surveillance measure (The eligible hospital or CAH is in active engagement with CDC's National Healthcare Safety Network (NHSN) to submit AUR data for the EHR reporting period and receives a report from NHSN indicating their successful submission of AUR data for the EHR reporting period). To receive credit, eligible hospitals and CAHs must report a "yes" response or an exclusion for which they are eligible. There would be no additional points for reporting this measure. To report this measure, eligible hospitals and CAHs would have to use technology certified to the criterion at 45 CFR 170.315(f)(6), "Transmission to public health agencies – antimicrobial use and resistance reporting." Finally, the measure would be calculated by reviewing all patient records, not just those whose records are maintained using CEHRT.

Ascension supports the addition of the AUR surveillance measure; however, we believe the implementation timeline is too short to enable success, due to a number of factors. For one, providers are dependent on the public health authorities' ability to receive the exchange data and respond, a capability that is highly variable across states today. We encourage CMS to consider use of a step-wise timeline and associated measures that reward forward progress in implementing this exchange. Included in the timeline should be education, compliance with data standards, standardized implementation guides for all exchange parties, and analytics.

Additionally, we encourage CMS to allow time for vendor software improvement in the first year, adoption of the software changes in subsequent years, and completion with finished implementations and proof of exchange. In recognition of the amount of implementation work this measure would entail, we believe a stronger incentive should be applied to the final portions of the timeline to encourage completion. As proposed, the measure would be calculated by "review of all patient records," and we are concerned this would be overly burdensome on providers. We suggest, instead, that the measure be calculated based on all electronic records so that technology tools can be deployed to capture and analyze the data to reduce its burden on providers.

Proposed eCQM Adoptions

CMS intends to continue to align the Medicare PIP eCQM reporting requirements with similar requirements under the Hospital IQR Program. To that end, CMS proposes to adopt four new eCQMs for the Medicare PIP eCQM measure set: (1) Severe Obstetric Complications eCQM (NQF NA); and (2) Cesarean Birth eCQM (NQF NA); (3) Hospital Harm-Opioid-Related Adverse Event eCQM (NQF #3501e); and (4) Global Malnutrition Composite Score eCQM (NQF #3592e).

Ascension continues to appreciate CMS's efforts to streamline measures and reporting requirements across the myriad quality reporting programs.

Patient Access to Health Information Measure — Request for Information

CMS describes the benefits of the use of patient portals for individuals to access their health information, but it is concerned with the low uptake rate and use of patient portals. CMS says that close to two thirds of hospitals gave less than one quarter of their patients activate access to the hospitals' patient portals in 2017. Under the Patient Exchange Objective in the Medicare PIP, in response to stakeholder input, CMS removed the View, Download, or Transmit (VDT) measure because of the difficulties providers face with measures that require patient action. CMS made changes to the *Provide Patients Electronic Access to Their Health Information* measure to require hospitals to provide timely access for viewing, downloading or transmitting their health information for at least one unique patient discharge using any application of the patient's choice that is configured to meet the technical specifications of the API in the provider’s CEHRT. The emphasis of the measure was timely access rather than holding providers accountable for patient action. CMS is now balancing the barriers and challenges of the VDT measure with advancements in the health IT industry and seeks comments on how to promote equitable patient access and use of their health information without adding unnecessary burden on providers.

In Ascension's experience, we have found that patients commonly have difficulty understanding at least part of their records and that additional tools and patient-friendly translations are necessary to help with translating vocabulary or meaning. We have also found it is not uncommon that patients are asked to navigate unique portals to each of their providers, which creates confusion, frustration, and an undue burden in obtaining their records– in turn discouraging use of such portals. Streamlining and easing the process to access one’s record through use of technology like a records locator request system, which helps patients automatically bring their records together for viewing, would be extremely helpful to promote review and use.

Additionally, we believe there is a need for secure unique patient electronic verification processes to more quickly confirm a record requester’s identity. Finally, we have found that patient use of portals tends to increase when there are other beneficial capabilities simultaneously offered, such as appointment scheduling, prescription refills, and secure physician messaging.

We have found that the best predictors of access to online medical records by patients have been age, educational attainment, income, and internet access. The poorest and most vulnerable among us, as well as minorities and residents of communities without broadband or cellular internet access, have less access to digital health information technologies. And once accessed, for certain populations the information contained in a record may be confusing–especially if English is not the patient’s primary language.

Technology that provides reliable real time translation of information contained in the portal is thus beneficial to increasing use. Finally, we believe more education is needed, especially in poor and vulnerable communities, to encourage patients to access portals and assist patients with understanding how they can obtain benefit from use of the information. Given that barriers to access, difficulty in locating and understanding records, and patient concerns about security of their information remain, we do not support the addition of a measure of patient access at this time.

Condition of Participation: Reporting COVID-19 and Influenza Infections

CMS is proposing to revise the hospital and CAH infection prevention and control and antibiotic stewardship programs CoPs to extend the current COVID-19 reporting requirements and to establish new reporting requirements for any future PHEs related to a specific infectious disease or pathogen. CMS is proposing to require that, beginning at the conclusion of the current COVID-19 PHE declaration and continuing until April 30, 2024, a hospital or a CAH must electronically report information about COVID-19 and seasonal influenza in a standardized format specified by the Secretary.

Ascension supports the alignment of infectious disease reporting through NHSN, CDC-supported surveillance measures. However, we have found that there are some challenges which should be addressed to ensure successful implementation. For example, we encourage CMS to pursue alignment with state-based immunization registry requirements and local surveillance monitoring. Currently, confirmed COVID-19 patients are reported to the public health department, while different aggregate and patient-specific Influenza metrics are reported.

We would encourage CMS to align with mandatory public health reporting requirements to avoid duplicative reporting requirements on hospitals, particularly if it relates to person-level information. And we believe the "suspected" COVID inclusion in the metric will require standardized value sets and methodology for reporting. There are also several operational metrics proposed that will require data management and process alignment in order to effectively produce quality data with low latency: personal protective equipment and testing supplies in the facility; ventilator use, capacity and supplies in the facility; total hospital bed and intensive care unit bed census and capacity; staffing shortages; and relevant therapeutic inventories and/or usage.

Finally, the frequency and cadence of reporting must be balanced against CMS's need for 'real time' data, depending on how the agency plans to use data in a given moment. Based on our experience to date, we do not believe data should be reported daily or even weekly any longer, unless a clear and present need is demonstrated. Data reporting reprieves should be provided for weekends and holidays.

Additionally, we strongly encourage CMS to collect only that data which is actionable by CMS. For example, CMS has little to no ability to impact isolation capacity; this is something that is figured out at the local facilities level. If the goal is to measure availability of surge hospitals, this can be ascertained from total hospital and ICU bed data.

RFI: Payment Adjustments for Domestically Made N95 Respirator Masks

CMS states that in a future pandemic or COVID-19- driven surge, hospitals need to be able to count on PPE manufacturers to deliver the equipment they need on a timely basis in order to protect health care workers and their patients. Sustaining a level of wholly domestic production of surgical N95 respirators is integral to maintaining that assurance, according to CMS. However, wholly domestically made NIOSH-approved surgical N95 respirators are generally more expensive than foreign-made ones. CMS is considering IPPS and OPPS adjustments consistent with the policy goal of making sufficient supplies of NIOSH approved domestically manufactured N95 masks.

Ascension, like other health systems across the United States, endured significant shortages of key PPE and medical supplies throughout the pandemic, many of which persist today. If a supply, such as a surgical N95, can be sourced through the domestic channels, that approach is decidedly beneficial for many reasons. Therefore, we appreciate CMS's consideration of such a payment adjustment to offset the price premium, as such a policy would be greatly appreciated.

With respect to CMS's inquiry around how hospitals can determine if the surgical N95 respirators they purchase are wholly domestically made NIOSH-approved surgical N95 respirators and eligible for these payment adjustments, our supply chain can readily obtain this information from our suppliers.

And while ensuring a steady supply of N95 respirators is important to maintain safe care settings, we encourage CMS to examine incentives to purchase additional domestically produced PPE, such as gloves, gowns and other supplies. Additionally, we also encourage CMS to work with stakeholders to ensure that essential PPE can be easily obtained and tracked to reduce potential disruptions in the supply chain.

Conclusion

We appreciate your consideration of these comments. If you have any questions, or if there is any additional information we can provide, please contact Mark Hayes, Senior Vice President for Policy and Advocacy for Ascension, at 202-898-4683 or mark.hayes@ascension.org.

Sincerely,

Peter M. Leibold
Executive Vice President and Chief Advocacy Officer
Ascension